

NEW PATIENT MEDICAL INTAKE FORM

Name: _____ Date of Birth: _____ Today's Date: _____

Have you traveled outside of the country in the last 30 days? (circle one) **Y N** If yes when and where: _____

Have you had a fever, cough, sore throat, loss of taste or smell, chills, nausea or vomiting in the last 14 days? (circle one) **Y N**

If yes, describe: _____

ALLERGIES

NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

NO MEDICATIONS

MEDICATIONS (please list all)	DOSE	TIMES PER DAY

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Allergies/Asthma			
Anemia/Blood Disorder			
Cancer (type: _____)			
Crohn's Disease/Ulcerative Colitis/Gastrointestinal Diseases			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type: _____)			
Emphysema (COPD) or Lung Disease			
Epilepsy/Seizures			
Heart Disease			
Hepatitis (liver) Disease/Jaundice			
High Blood Pressure (hypertension)			
High Cholesterol			
Hypothyroidism/Endocrine Disorder			
Psoriasis/Eczema/Hives			
Renal (kidney) Disease/UTI (urinary tract infections)			
Migraine Headaches			
Stroke			
Parkinson's/Multiple Sclerosis			
Other:			
Other:			
Other:			

REVIEW OF SYSTEMS ✓ Please Check All That Apply to You NOW.

CONSTITUTIONAL

- Appetite Change
- Chills
- Fatigue
- Fever
- Night Sweats
- Weight Changes

HEAD, EAR, NOSE & THROAT

- Congestion
- Dental Problems
- Drooling
- Ear Discharge or Pain
- Facial Numbness
- Hearing Loss
- Mouth Sores
- Nosebleeds
- Runny Nose
- Sinus Pressure
- Sneezing
- Sore Throat
- Tinnitus
- Trouble Swallowing
- Voice Change

EYES

- Double Vision
- Eye Discharge
- Eye Itching
- Eye Pain
- Eye Redness
- Sensitivity to Light
- Visual Disturbance

RESPIRATORY

- Chest Tightness
- Choking
- Coughing
- Shortness of Breath
- Spitting up Blood
- Wheezing

CARDIOVASCULAR

- Chest Pain
- Irregular Heart Rate
- Leg Swelling
- Rapid Heart Rate
- Varicose Veins

BREAST

- Abnormal Changes
- Discharge
- Lumps
- Pain in Breast
- Tenderness

GASTROINTESTINAL

- Abdominal Pain
- Acid Reflux
- Black/Bloody Stool
- Constipation
- Diarrhea
- Hemorrhoids
- Jaundice
- Nausea
- Rectal Pain
- Vomiting

ENDOCRINE

- Cold Intolerance
- Heat Intolerance
- Excess Hunger
- Excess Thirst
- Excess Urination
- Loss of Hair

GENITURINARY

- Bladder Incontinence
- Blood in Urine
- Decreased Sex Drive
- Difficulty Urinating
- Flank Pain
- Genital Sores
- Increased Urination
- Menstrual Cycle Changes
- Nighttime Urination
- Painful Intercourse
- Painful Urination
- Penile Discharge
- Penile Pain
- Penile Swelling
- Pregnant or Possibly Pregnant
- Scrotal Swelling
- STD Exposure
- Testicular Pain
- Vaginal Discharge
- Vaginal Itching or Irritation
- Vaginal Odor
- Urine Decrease

MUSCULAR

- Back Pain
- Gait Problems
- Joint Pain
- Joint Swelling
- Muscle Pain
- Neck Pain
- Neck Stiffness

SKIN

- Acne
- Changes to Lesions or Moles
- Color Changes
- Itching
- Rashes
- Skin Dryness
- Skin Lesions
- Wounds

ALLERGY & IMMUNOLOGY

- Environmental Allergies
- Food Allergies
- Frequent Illness
- Recent Vaccine (in the last 6 weeks)
- Seasonal Allergies

NEUROLOGICAL

- Dizziness
- Difficulty Concentrating
- Facial Asymmetry
- Headaches
- Light-headedness
- Loss of Balance
- Memory Difficulties
- Numbness
- Seizures
- Speech Difficulty
- Syncope
- Tremors
- Weakness

HEMATOLOGIC & LYMPHATIC

- Bruises Frequently or Easily
- Clotting or Bleeding Disorders
- Enlarged Lymph Nodes

PSYCHIATRIC

- Agitation or Irritability
- Anxiety
- Behavioral Changes
- Confusion
- Decreased Concentration
- Depression
- Excessive Anger
- Hallucinations
- Hyperactive
- Mood Swings
- Self-Injury
- Sleep Disturbance or Changes
- Suicidal Ideas
- Emotional Abuse
- Physical Abuse
- Sexual Abuse

Date of Last Menstrual Cycle: __-__-__

Additional Symptoms or Changes Not Listed: _____

Patient Name: _____ Date of Birth: _____